HEALTH SELECT COMMISSION
Thursday 1 May 2025

Present:- Councillor Keenan (in the Chair); Councillors Yasseen, Clarke, Duncan, Garnett, Ismail, Havard, Rashid, Tarmey and Fisher.

Apologies for absence:- Apologies were received from Bennett-Sylvester, Thorp and Gill.

The webcast of the Council Meeting can be viewed at:-
https://rotherham.public-i.tv/core/portal/home

59. MINUTES OF THE PREVIOUS MEETING HELD ON 27 MARCH 2025

Resolved:-

That the minutes of the meeting held on 27 March 2025 were approved as a true and correct record of the proceedings.

60. DECLARATIONS OF INTEREST

There were no declarations of interest.

61. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no questions from members of the public or the press.

62. EXCLUSION OF THE PRESS AND PUBLIC

There were no items on the agenda that required the exclusion of the press or members of the public.

63. ADULT MENTAL HEALTH PATHWAY UPDATE

The Chair welcomed Andrew Wells, Head of Service, Safeguarding to the meeting and invited him to introduce the presentation.

The Head of Service, Safeguarding advised that Helen Fisher, Head of Specialist Service, Scott Matthewman, Assistant Director of Strategic Commissioning and Health Select Commission Link Officer and Claire Smith, Deputy Place Director, Rotherham Place, South Yorkshire Integrated Care Board had attended to support with the presentation as required.

They explained that Cabinet approved the implementation of the new adult social care mental health model for Rotherham in December This included a revised pathway, realignment of council employees to deliver social care roles and responsibilities and realignment of approved mental health professionals, who were previously seconded to Rotherham, Doncaster and South Humber NHS Trust, under the council management.

The intention was to embed a collaborative preventative approach, to strengthen partnerships and working along the mental health pathway and also to ensure that services were aligned with community mental health transformation and comprised both clinical and social care.

The Head of Service, Safeguarding explained that there was the desire to introduce the prevention agenda into the mental health pathway and raise social care profile to clarify and solidify what social workers could bring to the table for people with mental ill health. It was also intended to strengthen the recovery model by providing preventative and proportionate social care interventions which aligned with the model in place for health colleagues.

They explained that in previous years, the Council had little information that could be harnessed as evidence for Care Quality Commission inspection, and the revised model would provide that evidence. It was also intended to collectively strengthen the mental health crisis pathway across the Council's statutory partners and the voluntary and the community sector (VCS).

The pathway was implemented in April 2024 as a joint approach between the Integrated Care Board (ICB), RDaSH, primary care and urgent care. When the revised model was originally presented to Cabinet, there were concerns that there may be adverse impact on partners, particularly in urgent care, however initial impact assessment identified no adverse impact.

The support offered predominantly focussed on prevention and early intervention, and the promotion of resilience and independence through an enhanced front door for referrals. There was a new mental health enablement offer which supported people in a more person-centred way, and focussed on delivering the right support at the right time. The enablement pathway operated from existing community and health venues, but was augmented through the establishment of community groups.

From June 2024, the enablement pathway had 178 referrals to the 12-15 week enablement process, which was flexible to meet individual needs. At the point of Cabinet approval, there was an existing cohort using Wellgate Court, who saw no change to their service provision.

Since the development of the enablement pathway, five peer support groups within different community settings, where people wanted them to

be, were established. Within those settings support was provided for up to an hour for approximately seven people. They were in addition to the dedicated sessions at Wellgate Court, twice weekly, which supported an average of eight people per session. Ad-hoc support was also available if needed. 65 people were either screened as not appropriate or declined in the enablement offer.

As of June 2024, the Approved Mental Health Professional (AMPH) Service, the Council and RDaSH had agreed that the AMPH and the Crisis team needed to remain co-located, as this provided a robust partnership approach to crisis intervention. Where there was uncertainty around individual needs of those seeking support, a collective response could be co-ordinated in one visit rather than separate visits. That was working well and allowed the AMPH service to provide social care interventions as part of the crisis response, which had the potential in certain circumstances to prevent individuals going into crisis or needing longer term support.

The Head of Service, Safeguarding described that for the first time in 15 years the service had information and data to benchmark against other local authorities. Thy added that staff were receiving appropriate support and supervision, with a focus on wellbeing, and being a responsible employer.

In terms of the impact of the revised pathway, the prevention and early intervention approach was critical to supporting people at the right time, allowing individual need identification e.g. integrating somebody into the community, supporting somebody into training or employment, group activity to address loneliness etc. There was also the mental health act assessment duties that sat within the team which were undertaken as and when required. Again, social care and health interventions could be considered concurrently due to co-location.

The establishment of a robust enablement pathway also allowed the service to signpost into the most appropriate service, with established links to the voluntary community sector where social care or health support was either not wanted or needed. It also clarified roles and responsibilities, and provided a broader understanding of what social care and health could offer, which led to enhanced partnership working and clarity regarding who would respond and when as part of a collaborative mental health crisis response.

The Head of Service, Safeguarding noted that the preventative offer had been particularly beneficial, as had the peer support groups. Data capture and analysis in relation to activity had facilitated succession planning and feedback sought was positive and acknowledged the value of the offer to individuals supported.

They explained that work was underway in relation to the co-produced mental health strategy, which was due to be presented to Cabinet in

December 2025. The 12-week consultation period would commence in May 2025, with the resultant strategy providing a framework for the future evolution of the pathway.

The Chair thanked the Head of Service, Safeguarding for the presentation and invited questions and comments.

Councillor Garnett referred to paragraph 1.3 of the report which discussed the intended benefits. They wanted to understand whether those benefits had been realised, or evidence of progress towards their realisation.

The Head of Service, Safeguarding advised that the period post implementation had given the service an opportunity to observe and refine targeted benefits and draw on the data gathered to consider the best way to measure progress going forward, and how pathways should evolve to meet needs. Complaints monitoring and member enquiries remained a key measure of performance. They added that there was a learning disability neuro diverse transformation group, which considered themes and trends.

Councillor Fisher queried the figures referred to on page 74 of the agenda pack concerning 65 individuals screened not appropriate or who declined the enablement offer. They wanted to understand how many were deemed inappropriate versus how many had declined the offer, and if any common themes or trends were identified in relation to that.

The Head of Service, Safeguarding clarified that a total of 220 referrals were received, which saw 151 people go through the enablement pathway, of which 69 remained open cases. Of the numbers referred to, eight clients had declined support. In some cases, this was because it was not the right time for them or there were difficulties engaging, however the offer remained and could be take up at any time. In relation to the 55 deemed inappropriate, this because it was believed the enablement pathway would not be successful in reducing their need. They were not left without support, but instead referred onto other services such as primary care that were better placed to address the needs of the individual in question.

Councillor Duncan sought clarity in relation to paragraph 2.9 of the report included in the agenda pack regarding benchmarking. They queried what data had or would be benchmarked, and how that had or would help the service and scrutiny assess performance and the success of the revised model.

The Head of Service, Safeguarding explained that the data provided information regarding the age and gender etc of service users, length of wait for assessment, length of the assessment process, assessment type and so on which allowed crisis trends and themes to be examined to inform future service planning and provision. Data gathering was underway, so benchmarking had not yet been undertaken, but would

allow an objective assessment of performance and delivery in comparison to peers. The data also offered evidence that would benefit the CQC (Care Quality Commission) inspection process around numbers that had accessed support.

They added that the enablement pathway was not a universal offer across the country, so the data and benchmarking offered an opportunity to assess and consider how best to utilise the pathway to deliver impact locally. This could be in relation to the location of services within communities where there was the greatest incidence of need for example, to maximise awareness and accessibility to those in need of support.

The Head of Service, Safeguarding confirmed that the data was not yet complete, and that benchmarking was yet to be undertaken.

Councillor Havard noted the absence of reference to male suicide within the report and presentation, and added that they were aware that a lot of men's mental health awareness and prevention work within the borough was delivered through the voluntary and community sector which represented a significant burden. They wanted to understand how those services interacted with primary care, Council services and so on.

The Head of Service, Safeguarding illustrated the Council's well-established close working relationship with the voluntary and community sector as part of the community offer. They confirmed that the pathway had clear links to the suicide prevention pathway and worked collaboratively to identify trends and themes in conjunction with the Council's suicide strategic lead. Training was also offered to anyone who requested it regarding suicide prevention, alongside the ongoing promotion of suicide prevention training for Council staff and the zero suicide alliance training package was offered to all providers and the voluntary and community sector. Work was also ongoing with Speak Up to make training accessible to people with autism, and promote autism training alongside that.

They added that the service had noticed an increase in need from older adults as well as men, and also amongst members of the LGBTQ+ community. As such means of maximising the reach of the suicide prevention training offer amongst those groups was being explored.

Councillor Havard queried whether the training offer had been extended to GP surgeries and particularly reception staff, as experiences shared from Rotherham residents reflected that GPs were often the first point of contact, but that those in need struggled to access timely support.

The Head of Service, Safeguarding advised that they believed that GPs were included in the offer, but would be happy to explore any particular targeted approaches that might assist in supporting crisis intervention and suicide prevention and encouraged contact from Councillor Havard outside of the meeting to explore this further.

Councillor Clarke highlighted the enhanced partnership working and enhanced personalised community offer for unpaid carers referred to in the agenda pack. They explained that in some communities within the borough, support groups were lost due to low numbers and left those in need without support. They wanted to understand whether work had been done to consider the barriers to attendance and participation, or the impact of relocation on service users prior to support being withdrawn. They sought reassurance that provision would be made for those in need to access appropriate support within their local area.

The Head of Service, Safeguarding acknowledged that the contribution of unpaid carers was significant, and responded that the service would welcome working with any such groups, particularly in terms of the mental health offer. They were keenly aware that the service had responsibilities not just towards service users themselves, but also unpaid carers supporting them and would be happy to look to establish additional community groups where there was the need and emphasised the value and validation peer support offered. They also highlighted the role of the carers assessment in identifying need.

Councillor Clarke confirmed that they would welcome further conversations around this with a view to bridging the identified gaps in support offered within some communities.

Councillor Ismail asked for the service to elaborate on what was meant by appropriate support for staff referred to on page 75 of the agenda pack, and queried whether there was any supporting data.

The Head of Service, Safeguarding advised that the Council offered staff wellbeing support across all services, but acknowledged the challenging nature of the role for staff supporting those with complex mental health needs. The services management approach to staff support and wellbeing within adult social care included monthly one-to-one meetings with a wellness focus. This was augmented by the employee assistance programme and referrals to occupational health as needed .

They added that a FTSU (Freedom To Speak Up) programme had recently been introduced across the Council, which emphasised the responsibility to communicate concerns or anything else adversely affecting service delivery or individuals. This was to be supplemented further with staff ‘Speak Up Champions’ to offer additional support.

Councillor Fisher noted that through interactions with members of the public, Councillors were aware of markers that may be applied to an individual or an address connected to adult social care or mental health issues. They wanted to understand how decisions to apply markers were made.

The Head of Service, Safeguarding stated that a unique identifier was assigned to all service users, which was used to anonymise data concerning location etc, subsequently used in service planning and targeted delivery, when cross-referenced with JSNA (Joint Strategic Needs Assessment) data. They added that some service users had a forensic history with associated risks that required the Council to implement safeguarding measures to mitigate those risks for the safety of both the service user and members of staff. In those cases, markers were applied to ensure that staff were alerted to any risks and could take the appropriate steps, with each individual case assessed and managed on its own merits and with the appropriate involvement of relevant organisations such as the police service, the probation service and NHS professionals. The further explained that there were legislative controls around the way the service could work with certain individuals.

Councillor Fisher sought reassurance that markers were reassessed over time to take account of changes in circumstances, location etc.

The Head of Service, Safeguarding confirmed that the service worked closely with housing to ensure address changes were promptly captured, and markers updated accordingly.

Councillor Havard queried how the service distinguished between those in need of soft support and those with significant mental ill health with more complex needs.

The Head of Service, Safeguarding explained that needs assessments were assisted by formal diagnoses, accepting that at earliest presentation there was not always a diagnosis in place. To address those areas of uncertainty, the vulnerability pathway was developed which comprised of different elements such as early intervention and enablement and utilised relevant partners under the MARAC (Multi-Agency Risk Assessment Conference) and VARM (Vulnerable Adult Risk Management) process to identify the level of need and implement appropriate support. They explained that there was a dedicated dual diagnosis worker in place, as it was often the case that mental health presented with substance misuse as a form of self-medication.

In each individual case, responses were person-centred, based on individual needs and risk assessments, focussing on the service users self-identified goals and targeted outcomes.

Councillor Havard wanted to understand what action members should take if they identified individuals through their ward-based work who were in need of support.

The Head of Service, Safeguarding explained that the service had recently revised the vulnerability pathway achieving a single referral point accessible to anyone.

Councillor Havard advised that they during previous discussions at the Improving Lives Select Commission, it had been recommended that housing staff were equipped to identify individuals who may in need of additional support. They queried whether this recommendation had been progressed with the service.

The Head of Service, Safeguarding advised that there was joint work underway with housing with whom they worked very closely to deliver complementary support and interventions. Bespoke mental health and safeguarding training had been provided to housing officers also.

Councillor Havard wanted to understand whether the targeted improvements or anticipated changes to the co-produced mental health strategy due to be presented to Cabinet in December were known.

The Head of Service, Safeguarding advised that the service was in the early stages of planning. The 12-week consultation period was due to begin in May 2025 and would take account of view from service users, delivery partners and the voluntary and community sector. No themes of targeted improvements had been identified and the process was intended as true co-production, drawing on the views shared through the consultation process.

Councillor Yasseen wanted to understand whether the revised pathway had created efficiencies that had or would result in job losses.

The Head of Service, Safeguarding confirmed that the service had committed to maintaining the staffing establishment, so there were no job losses as a result of the changes implemented.

Councillor Yasseen commented that it would have been helpful for additional data around the composition and demography of service users to highlight any themes or particular areas of need, and equally potentially identify groups or communities who are not engaged with services and where more could be done.

The Head of Service, Safeguarding advised that the service consistently considered how it engaged with communities. There had been targeted work undertaken to improve engagement with Asian communities and victims of domestic abuse, as it was identified that those areas were under-represented.

Councillor Yasseen wanted to understand whether there would be any key performance indicators (KPI) or wider equality objectives associated with the co-produced mental health strategy, and if so how performance against those KPIs would be monitored and managed.

The Head of Service, Safeguarding advised that following approval of the strategy, a number of priorities would be identified against which KPIs would be set.

Councillor Yasseen sought assurances that where the service had previously seen particular spikes in suicide rates or crises, lessons were learned and provision designed to address the needs of affected groups.

The Head of Service, Safeguarding highlighted the role of the strategic and operational suicide prevention leads within the Council, and how they worked with delivery partners and the voluntary and community sector to address the trends and themes identified through activity analysis. In some cases, there had been ward specific interventions and initiatives, in other cases, initiatives were targeted at primary care but always with collaboration at the core.

Councillor Yasseen suggested that it may be prudent share the suicide prevention strategy with members of the Health Select Commission, and consider a workshop or briefing if required.

Resolved:-

That the Health Select Commission:

1. Noted the impact of the Adult Social Care Mental Health model of provision following its implementation in April 2024 and the planned development of a co-designed Council Mental Health Strategy due to be presented to Cabinet for approval in December 2025.

2. Requested the opportunity to review the mental health strategy due to be presented to Cabinet for approval in December 2025 prior to that time in order to consider its contents and offer comments and suggestions as part of pre-decision scrutiny which falls within the Commission's remit.

3. Requested that benchmarking/comparison data referred to in the report and presentation be shared with the Health Select Commission at the earliest opportunity following this becoming available, to allow members to assess performance in the area.

64. HEALTH SELECT COMMISSION WORK PROGRAMME - 2024/2025

Resolved:-

That the Health Select Commission:

1. Approved the work programme.

2. Agreed that the Governance Advisor was authorised to make any required changes to the work programme in consultation with the Chair/Vice Chair and report any such changes back to the next meeting.

65. SOUTH YORKSHIRE, DERBYSHIRE AND NOTTINGHAMSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

The Chair advised members that there had been no meeting of the South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee (JHOSC) since the last Health Select Commission meeting.

They shared details of items JHOSC were due to consider during the course of the coming municipal year, reiterated the Health Select Commissions representation at that Committee, and requested that members duly notify the Chair or Governance Advisor of anything they would like to be raised on their behalf in relation to items scheduled for consideration during any future JHOSC meetings.

66. URGENT BUSINESS

There was no urgent business to discuss.

67. DATE AND TIME OF NEXT MEETING

Resolved:-

That the Health Select Commission noted that the next meeting would take place Thursday 26 June 2025 at 5.00 pm.